N.H. Medicaid Care Management

Care Management Information Meetings

August 2012

Contents

Overview

In June and July 2012, the New Hampshire Department of Health and Human Services (DHHS) held 12 information sessions across the state to discuss the Medicaid Care Management program with program beneficiaries, providers and other stakeholders.

Information covered during the sessions was on Step 1 of the new Medicaid Care Management program scheduled to launch at the beginning of next year. The first step encompasses those Medicaid services that address medical needs, such as doctor visits, impatient and outpatient hospital visits, prescriptions, mental health services, speech therapy and audiology services. Enrollment for the new program is now projected to begin in November and services in January 2013.

The sessions discussed when the new program will start, what people will have to do when enrolling in the program, how people can choose a Care Management health plan and how the new program will work.

The sessions were held in Berlin, Claremont, Concord, Conway, Derry, Dover, Keene, Laconia, Littleton, Manchester, Nashua and Portsmouth. Approximately 1,152 people attended the 12 sessions. Of those in attendance, half were Medicaid consumers and family caregivers.

The sessions accomplished their goal: providing people with concrete, factual information about the care management program and lowering anxiety about the change.

Attendees appeared to appreciate the opportunity to learn about program specifics from high-level Department staff members and the opportunity to have their many questions answered, both during the presentations and after the sessions had ended.

Purpose

The sessions were intended to inform those who use Medicaid services, family members, caregivers, human service agency case managers or service coordinators who work with Medicaid recipients, as well as those who have an interest in how New Hampshire Medicaid operates about the new Care Management program. Sessions covered how Care Management differs from the current program, its features and benefits and the timeline for enrollment.

The information presented at each session was essentially the same, although the presentation was refined during the course of the 12 sessions, reflecting the input from meeting participants and the Department's immediate response to that input. A copy of the presentation is included as Appendix B.

Facilitators

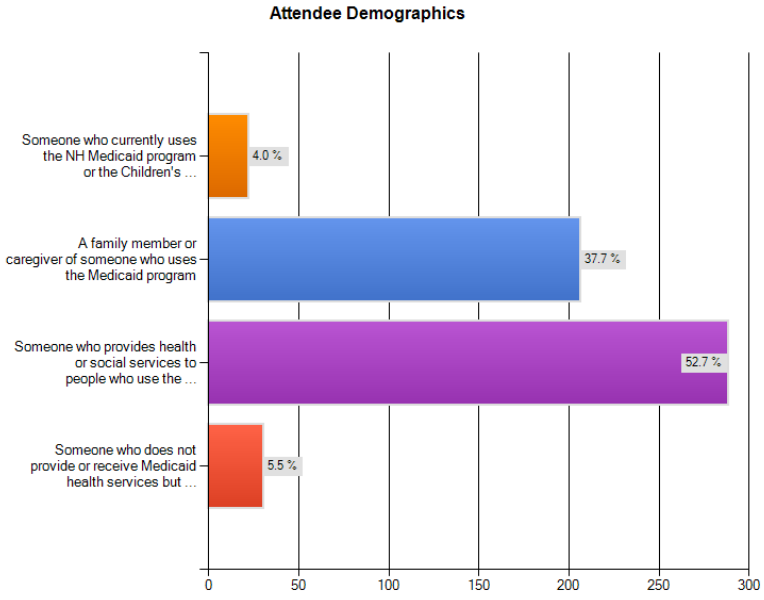
The following senior DHHS staff members facilitated the sessions:

- Commissioner Nick Toumpas
- Associate Commissioner Nancy Rollins
- State Medicaid Director Katie Dunn
- Lisabritt Solsky, Deputy Director, Office of Medicaid and Business Policy
- Matthew Ertas, Administrator, Bureau of Developmental Services
- Chris Shannon, Administrator, Office of Medicaid and Business Policy

Analysis of Attendees

Approximately 559 people of the 1,152 who attended chose to pre-register for the information sessions and we obtained information on which stakeholder group they were part of. Of those pre-registered:

- 4% were people who currently use the New Hampshire Medicaid program or the Children's Health Insurance Plan (CHIP)
- 38% were a family member or caregiver of someone who uses the Medicaid program
- 53% were professionals who provide health or social services to people who use the Medicaid program
- 5% were people who do not provide or receive Medicaid health services, but who have an interest in how the New Hampshire Medicaid program operates



Those who pre-registered posted approximately 105 questions that they wanted to see covered in the presentation. These were provided to the DHHS session facilitators before each meeting.

Attendance

According to the sign in sheets from each of the sessions approximately 1,152 people attended the 12 sessions.

Location	Date	Attendance
Berlin	7/12	16
Claremont	7/9	80
Concord	6/27	154
Conway	6/14	23
Derry	6/26	112
Dover	6/12	110
Keene	6/19	86
Laconia	6/25	77
Littleton	6/18	50
Manchester	6/13	95
Nashua	6/28	204
Portsmouth	7/10	145

Questions

Those who attended the sessions asked more than 356 questions – not including those asked on an individual basis or in small groups.

Questions fell into 10 broad categories as follows.

Eligibility, e.g. If people choose to opt out are they off Medicaid?

A: No, there is no change. Those who opt out will be in the Medicaid fee for service program.

Enrollment, e.g If we need assistance with enrollment and choosing a plan, who do we contact?

A: DHHS will provide access to staff fully trained to assist with the enrollment process and decision-making.

Care Management, e.g. Who is the care manager? What is the training of a care manager?

A: The care manager works for the health plan and has the responsibility to facilitate desired outcomes for certain members with chronic conditions. Each health plan has training requirements for staff and the care managers will be trained based on their requirements. Most care managers have nursing, therapy, or social work backgrounds.

Choosing a plan, e.g. How will we know which plan our current providers are in?

A: The Department will have a list of all providers that are in each network with the health plans, and the information will be on our website.

Covered services, e.g. Who is paying for prescriptions?

A: The pharmacy benefit is part of the care management program and will be administered by the health plans.

Out of state specialists, e.g. Will recipients be able to use out of state doctors?

A: Possibly. Out of state doctors need to agree to be part of the health plan's New Hampshire network.

Coordination with other insurance, e.g. Will we lose access to our private insurance?

A: No, private insurance is the first form of funding for services. Medicaid or Managed Care will not adversely impact accessing your private insurance.

Program communication, e.g. Where can people find information if they need help?

A: There is an enrollment telephone number people can call for more information. We are planning provider training sessions, too. The new website also will have information to help you.

State oversight and funding, e.g. Why are there three health plans?

A: There are three health plans because the federal government requires at least two in order to give consumers a choice.

Step 2, e.g. When does Step 2 begin?

A: Step 2 is scheduled to start one year after the start of Step 1.

In general, the questions asked by people who attended each session tended to be similar. These were documented at each meeting and form the basis of the *Care Management Questions & Answers* document that has been developed and placed on the Department's Care Management webpage and which is attached as Appendix C of this report.

Department staff tried to answer every question that people had at the session. They took questions during the presentation and then for 30-60 minutes afterwards until no one had any more. In addition, staff provided direct contact information to attendees who had specific questions that required follow up, as well as also helping attendees with non-care management related issues.

Results

Each session was remarkably similar in that the tone of comments and questions at the beginning indicated audience members' fear and skepticism about the change to Care Management. After the details of the new program were laid out and questions addressed this general anxiety seemed to subside a good deal. In fact, near the end of each session it was common to hear someone, who had the option to opt out of Step 1 and stay in the traditional fee-for-service model for another year, ask if they might be better off opting in.

At the end of each session it was also common for audience members to recommend to Department staff that they reach out to other groups to provide similar training on Care Management – which the Department said it planned to do.

While skepticism about the change in the Medicaid program certainly remains, the effort to reach out to stakeholders appeared to have accomplished its goal of providing concrete information about the new program and reducing anxiety about the change.

Next Steps

- Publishing this report and reviewing it with the Medical Care Advisory Committee.
- Development and implementation of a comprehensive outreach and education plan to include member and provider communications.
- Scheduling of provider information sessions and additional information sessions for consumers and caregivers.

N.H. Department of Health and Human Services
Medicaid Care Management
Step 1 Medical Services

Program Timeline

September: You'll get an information letter from DHHS. No action needed.
October: You'll get detailed managed care company information from DHHS.
November: You can choose a health plan. If you don't choose a plan, we will pick one for you.
January 2013: The new program begins.

*Dates subject to change pending Centers for Medicare & Medicaid Approval

Medical Services in Step 1:

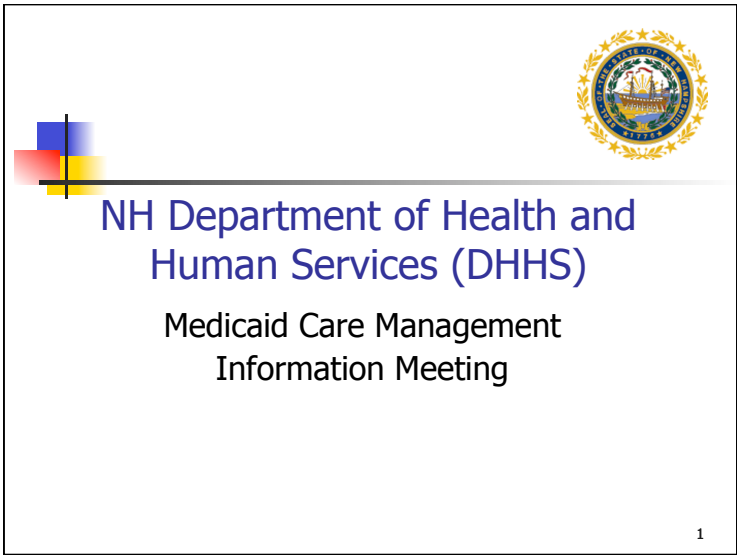
- Doctors visits
- In-patient and out-patient hospital visits
- Prescriptions
- Mental health services
- Family planning
- Home health services
- Speech therapy
- Audiology services
- Durable medical equipment
- Physical therapy
- Occupational therapy
- Personal care services
- Private duty nursing
- Adult medical day care
- Ambulance services
- Wheelchair van
- Optometric services (eye glasses)
- Fluoride varnish for children

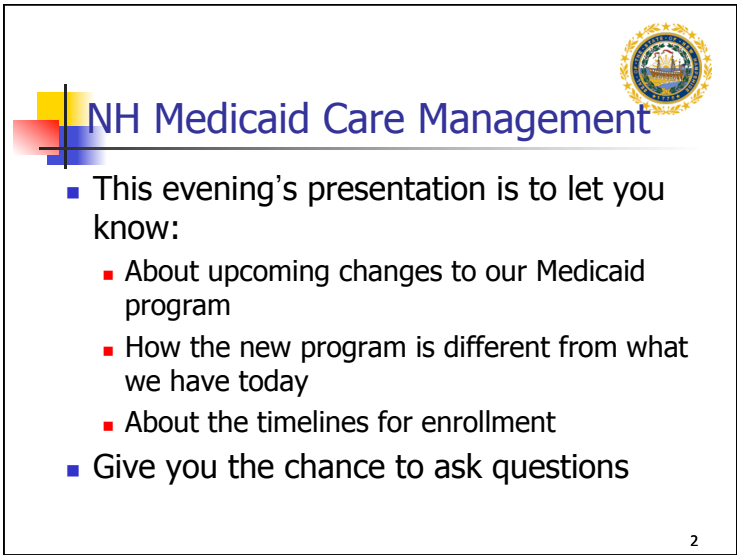
For more information visit:

www.dhhs.nh.gov/ocom/care-management.htm

Questions? Email nhmedicaidcaremanagement@dhhs.state.nh.us

7/20/12


NH Department of Health and Human Services (DHHS)
Medicaid Care Management Information Meeting
1


NH Medicaid Care Management
This evening's presentation is to let you know:
About upcoming changes to our Medicaid program
How the new program is different from what we have today
About the timelines for enrollment
Give you the chance to ask questions
2

What is Medicaid in NH?

- NH Medicaid is a safety net of health related services for people who meet certain income and eligibility requirements
- The program provides health care services and other supports for pregnant women and children and individuals who are elderly and who are disabled

3

Why is NH's Medicaid Program Being Changed?

- Governor Lynch and NH Legislature passed new law establishing Medicaid care management program
  - Chapter Law 125, Laws of 2011 (SB 147)
- Law requires the Department of Health & Human Services (DHHS) to set up a managed care program
  - We call it **Care Management**
- The goal is to improve access to care, quality of care and overall health status, while at the same time improving cost effectiveness
- The Department is launching these sessions to begin to share information with those on Medicaid

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Care Management Program Implementation

DHHS is implementing Care Management in three-steps:

- **Step 1** (This year):
  - The program includes everyone who is receiving Medicaid funded health care (with some exceptions)
- **Step 2** (Next year):
  - The program becomes mandatory for everyone receiving Medicaid (no opting out)
  - Medicaid Waiver and nursing home services are added
- **Step 3** (2014):
  - Affordable Care Act allows states to expand Medicaid to include adults who fall below certain income levels
    - (~$15,000/yr for single, ~$30,000/yr for family of 4)

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We are here this evening to talk about Step 1

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Who is included in Step 1?

There are two groups in Step 1:

- **Included:** Everyone using Medicaid
- **Can Opt-out during Step 1**:
  - Children in Foster Care
  - Children with special health care needs
  - Home care for children with severe disabilities- Katie Beckett
  - Children with Supplemental Security Income (SSI)
  - Dual Medicare and Medicaid eligible

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Who's excluded?

Individuals in the following categories:

- Spend-down
- Veterans Administration
- Qualified Medicare Beneficiaries (QMB)
- Special Low-Income Medicare Beneficiaries (SLMB)
- Qualified Disabled Working Individual (QDWI)

These programs remain the same as they are today.

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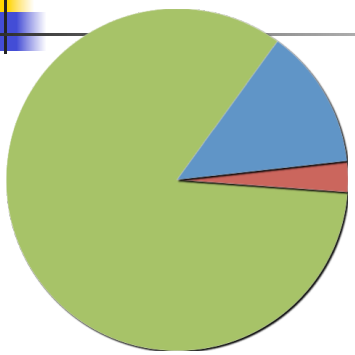
NH Department of Health & Human Services
Medicaid Care Management Program



Year 1 Opt Out of Care Management; Still in Medicaid Fee-For-Service
Members also covered by Medicare
Foster Care/Out-of-Home Placement/ Adoption Assistance
Certain Disabled Children (e.g., SSI, Katie Becket)

Excluded from Care Management;
Neither eligible or mandated to join a health plan
Members receiving VA health care system benefits
Medicaid In and Out Program (spend-down)
Still in same Medicaid Fee-for-Service as today

All Medicaid Recipients

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What services are included in Step 1?

- Doctors visits
- In-patient and out- patient hospital visits
- Prescriptions
- Mental health services
- Family planning
- Home health services
- Speech therapy
- Audiology services
- Durable Medical Equipment
- Physical therapy
- Occupational therapy
- Personal care services
- Private duty nursing
- Adult medical day care
- Ambulance services
- Wheelchair van
- Optometric services (eye glasses)
- Fluoride varnish by doctor for children

Note: These services provided today with the exception of fluoride varnish by doctor for children

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What is different or same?

Now	Care Management
▪ We (DHHS) handle Medicaid eligibility	▪ We (DHHS) continue to handle Medicaid eligibility
▪ Standard set of services	▪ Standard services remain the same
▪ We issue Medicaid cards	▪ You pick a health plan. The health plan also sends you a card
▪ Individuals go to multiple places for care (uncoordinated)	▪ You pick a primary care doctor or clinic from the health plan's provider list
▪ We pay doctors and hospitals directly	▪ The health plan coordinates your care in consultation with you and your doctor
	▪ The health plan pays doctors and hospitals

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What is a Managed Care Organization (MCO)?

MCOs are companies that contract with doctors, nurses and other providers -who work together- to provide your health care. While often referred to as MCOs, we will refer to the companies as Health Plans.

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Let's look at some examples of individual situations to better understand Care Management and its potential benefits

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Adult with Mental Health needs

- 55 year old experiencing severe anxiety and depression
  - Her primary care physician began to prescribe medications for her anxiety and depression
- Has high blood pressure, high cholesterol, and been struggling with severe weight problems
- Began to see a private independent psychotherapist who referred her to an independent psychiatrist
- The psychiatrist took over prescribing the medications for symptoms of anxiety and depression.
  - The primary care doctor continued to prescribe the same medications
- Experienced serious medical and cognitive complications from overuse of the medication and was admitted to inpatient care

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Adult with BH/MH needs under Care Management

- The **care manager** will reach out to the person to assist with referral and linkage to appropriate care providers
- The care manager will have the ability to review all standing orders for treatment and medications
- The care manager will have seen the request for payment on the duplicate prescriptions
- The care manager is expected to have contacted the primary care and pharmacy to terminate the duplicate psychiatric medication order

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Child with chronic health issues

- An eight-year-old boy with poorly controlled asthma
- Does not have a regular primary care physician
- On medication for treatment of his asthma, including inhalers
  - But does not use them correctly
- Lives with his single father in an old, carpeted, poorly ventilated apartment
- In the last year he has had four emergency room visits, requiring emergency treatment for breathing difficulties

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Child with chronic health issues under Care Management

- Care management would identify and connect the family with a **primary care provider (PCP)**
- Review current medications and father's level of understanding about asthma treatment
- Evaluate asthma triggers within the home and provide education to father
- Asthma **plan of care** outlines responsibilities of all involved care partners
  - Including family, school, child care providers, health care providers and other community resources, such recreation programs
  - Improving overall **care coordination**

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Teen with Autism

- 15-year-old with autism and anxiety
- Recently started having seizures
- Evaluated by a neurologist in Boston and started on seizure meds
  - Took three months for the appointment with the neurologist.
- Was not responsive to the first trial of seizure medications and had a prolonged seizure at school.
  - The school was not aware that she had a medication order from the neurologist to be used on an as needed basis, which would have stopped the seizure
  - She was taken to the emergency room by ambulance
  - Neurologist made a change in seizure medications, which resulted in increased anxiety
- Her school attendance and performance has suffered as a result and her parents have missed several days at work

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Teen with Autism under Care Management

- **Coordination between primary care physician and specialist** for management of anxiety
  - Making sure neurologist is aware of diagnosis of Autism and issues around anxiety to facilitate informed choice of seizure medications to avoid negative interactions
- Ensure communication with the school regarding treatment
- Increased co-management between primary care physician and specialist could have resulted in family not needing to wait for the neurological appointment or travel as far
- **Seizure treatment plan** outlines responsibilities for all involved care partners including family, school, health care providers and other community resources

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Woman with Developmental Disability (DD)/Intellectual Disability (ID)

- Fifty year-old woman with Down Syndrome
  - Has a thyroid disorder and is overweight
- She has recently become irritable and forgetful and has stopped wanting to go to work or participate in her walking group
- Has not received regular health and wellness screenings appropriate for women her age
- She has been to see her primary care physician who told her mother that these symptoms are not unusual for an older woman with Down Syndrome.

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Woman with DD/ID under Care Management

- Care management would offer standard medical evaluation
  - Ensure full complement of **typical health and wellness screenings** such as mammogram, colonoscopy, gynecologic screenings
- Treatment of thyroid condition
- Depression screening
- After ruling out medical causes for recent changes in function and mental status, consider neurological evaluation to identify possibility of early onset dementia

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Elderly with medical issues

- 87-year-old woman with advanced Multiple Sclerosis
- Utilizes a combination of services to live in her home by herself
- Developed many medical complications due to inconsistent care provided through paid and unpaid caregivers
  - Inpatient admissions for management and resolution of medical problems

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Elderly with medical issues under Care Management

- Better **coordination** of services could lead to her care being provided in a more consistent manner
- Would decrease or eliminate the now frequent acute care needs and inpatient stays
- Coordination would include the development of a comprehensive **service plan** with provisions for safety/emergency so that she can safely remain in the community

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Pregnant Woman with Limited English Proficiency

- Betsy is 27 y.o. Russian woman who has been in the US for approximately 3 months. She is pregnant with her first child.
- Betsy's English speaking is very limited and she requires a interpreter at appointments
- Her unborn baby has been diagnosed with a heart defect that will require surgery immediately after birth

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Pregnant Woman with Limited English Proficiency

- Community health center nurse midwife arranged for evaluation by a pediatric cardiologist who will monitor the baby. The midwife recommends birth at the local hospital with transport of the baby to a specialty hospital following the birth; that hospital wants a guarantee of payment up front
- The cardiologist is concerned that labor and delivery will stress the baby so recommends C-section at a different specialty hospital
- She has also been referred by the health center to a high risk obstetrician who recommends a C-section at a hospital with a Neonatal Intensive Care Unit
- Betsy is overwhelmed and confused both because of the differing opinions and her limited English. She does not know the right choice for herself and her baby.

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Pregnant Woman with Limited English Proficiency under Care Management

- Care Manager (CM) assigned at the first indication of complications. Assures translation for every appointment
- CM arranges a conference call among all the physicians, Betsy, a qualified interpreter and the care manager.
- CM would facilitate ongoing sharing of information between the three medical offices

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Pregnant Woman with Limited English Proficiency under Care Management

- CM would support and assist Betsy in making the best birth plan including location and attendant, considering her baby's needs
- CM would ensure Betsy is linked with WIC, Special Medical Services and other community supports while also helping Betsy in her emotional and physical needs leading up to her delivery
- CM will work with hospital discharge planner to support Betsy and baby at home post delivery

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Critical Elements of Care Management

- **Care Coordination**
  - Across all need areas (physical health, mental health, social)
  - Across all providers (getting all providers to communicate and collaborate with each other)
  - Facilitating accessing of services and achieving outcomes
  - Link people with other state, local, and community programs that may provide or assist with related health and social services
  - Helping individuals to acquire self-care skills
  - Supporting care-giving families

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Care Management vs. Case Management

- **Care Management** is different from the "case management services" that are provided under the current Medicaid program
- Care management will be provided only to those who have extensive and chronic needs
  - Not every person will receive care management
- Care management provided by managed care organizations will not replace the current case management services
  - Provided by mental health centers, area agencies, or independent case management organization
- Care management will be used to complement case management services to achieve better outcomes for people

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Critical Elements of Care Management

- **Patient-Centered Medical Homes**
  - Connection to a Primary Care Provider (PCP)
  - Person's needs are the focus of the care
  - Screenings and assessments to identify person's health care needs
  - Monitoring and reassessing needs
  - Evidence-based practices (using proven successful methods of care)
  - Integration of primary care and mental health services

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Critical Elements of Care Management

- **Chronic Care and High Risk Management Programs**
  - Assist individuals in the management of their chronic diseases
    - Diabetes, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, Coronary Artery Disease, Obesity, and Mental Illness
  - Use "whole person" approach to ensure that the person's physical, behavioral, developmental, and psychosocial needs are comprehensively addressed

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Critical Elements of Care Management

- **Wellness and Prevention programs**
  - Provide individuals with general health information
  - Provide services to help people make informed decisions about their health care needs
  - Encourage individuals to take an active role in shared decision making about their care
  - Develop and implement programs designed to address childhood and adult obesity, smoking cessation, and other similar type wellness and prevention programs
  - Encourage individuals to complete an annual health risk assessment

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Critical Elements of Care Management

These elements are not options. They are contractual requirements to which the Health Plans will be held accountable to by the State.

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Who are the three Health Plans?

- Boston Medical Center Health Plan
- Granite Care-Meridian Health Plan of New Hampshire
- Granite State Health Plan (Centene Corp)

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Care Management

Timeline for Step 1
2012-2013

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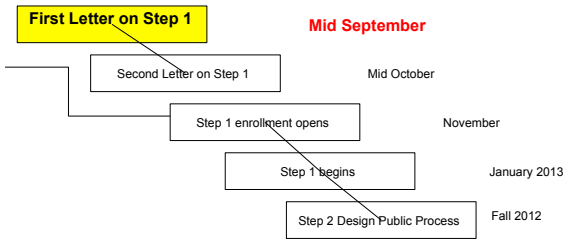
Care Management Timeline



Dates subject to change pending
Centers for Medicare & Medicaid Approval

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We send you a letter in Mid-September on Step 1

- **Does not require you to take any action**
- Informs you of upcoming changes to the Medicaid program
- Provides information on next steps
- Provides how to get more information

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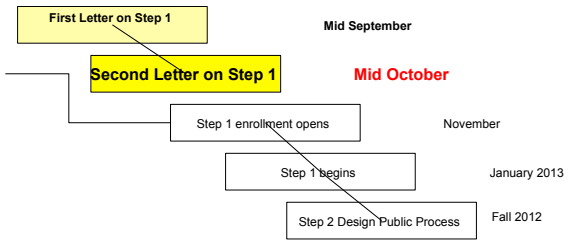
Care Management Timeline



Dates subject to change
Centers for Medicare & Medicaid Approval

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We send a second letter on Step 1: Mid-October

- Provides information about the three health plans
- Provides more detailed information about when and how to pick a health plan
- Gives updated information on the timeline
- Provides contact information to get help

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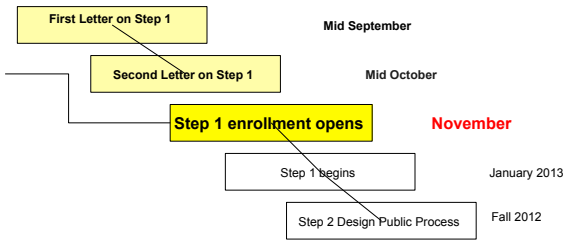
Care Management Timeline



Dates subject to change
Centers for Medicare & Medicaid Approval

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Enrollment begins: October

Action Required: You will need to pick a health plan. If you don't, we will pick one for you.

- Everyone who uses Medicaid begins to pick among the three managed care companies via mail, NH Easy, telephone
- We (the Department) will provide information about the three companies to help you pick one.
- When you choose a company, the company will send you a card that you will use when you go to a doctor or clinic for health services to use along with your Medicaid card.

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How do I choose a Managed Care Plan?

All three health plans cover the same basic services.

Do you want to keep your current doctor or clinic?	Check to see if they are on a health plan's list.
Do you see a specialty doctor?	Check to see if they are on a health plan's list.
Are doctors and clinics close to where you live?	This is important to look at on the plan's lists.
Are there services or benefits offered by one plan and not another that are appealing to you?	This may make one plan more appealing than another – if other parts are the same.

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Will I choose my primary care doctor?

- Yes. You will be able to choose your doctor from the managed care company's group of health care providers.
  - Some providers may be in more than one plan.
- Your primary care doctor is your personal doctor
- Some people who have needs for specialty services will coordinate the services with their doctor and managed care company.
- You have to use providers listed in your managed care plan
  - Primary care doctors, clinics, pharmacies, hospitals, mental health providers, etc.

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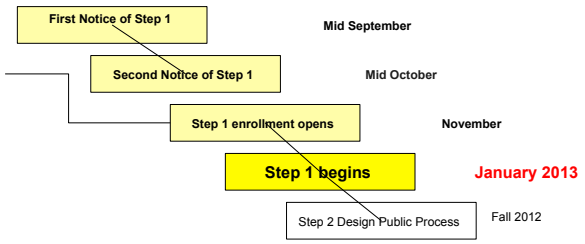
Care Management Timeline



Dates subject to change
Centers for Medicare & Medicaid Approval

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Program projected to begin in January 2013

- The health plans help you see the right provider when you need to
  - Through their network of doctors, clinics, pharmacies, mental health providers, etc.
- All Medicaid populations enrolled in program (with some exceptions)

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Step 2

- Specific elements of Step 2 have not been identified yet
  - DHHS has started working on this
- This fall DHHS will begin to reach out to all stakeholders for input on design of Step 2

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What services are in Step 2?

Community-Based Medicaid Waiver Services

Long Term Care Services such as Nursing Homes

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Timeline Recap

- **September:** You'll get a letter from DHHS
- **October:** You'll get detailed health plan information from us
- **November:** You can choose a health plan. If you don't choose a plan, we will pick one for you.
- **January:** The new program projected to begin

Note: If there are any changes to the timeline, DHHS will make announcements and provide updates

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What if I want to change health plans?

- If you are not happy with your company, you can switch to another within the first 90 days
- There will be annual open enrollment periods

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What will I do if I have a problem with the Health Plan (MCO)?

You will be given information when you enroll with the health plan about your rights and what to do should you have a problem.

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Questions

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For More Information

- Visit www.dhhs.nh.gov/ocom/care-management.htm for updates and this presentation
- Submit questions to:

nhmedicaidcaremanagement@dhhs.state.nh.us

- Website and toll free telephone number will be established in the coming months

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New Hampshire Department of Health and Human Services
August 2012

Medicaid Care Management Questions & Answers

The following questions were posed during the 12 information meetings held across the state in June and July, 2012.

Eligibility

1. When does Medicaid for Employed Adults with Disabilities (MEAD) become part of the care management program?
Individuals on MEAD are included in Step 1 of the program, which is scheduled to start in January, 2013.

2. If you meet your spend down for a certain amount of time can you qualify for the care management program if your case is opened up?
Individuals enrolled in Medicaid who have a spend down will remain in the current fee for service program and will have no change from their current status.

3. If you're on disability and spend down what are you on?
Individuals enrolled in Medicaid who have a spend down will remain in the current fee for service system.

4. What is opt out?
Under federal law certain Medicaid recipients can choose not to participate (opt out) in Step 1. Under Step 2, enrollment will be mandatory for everyone.

5. For those who fall into the category of "opt out," how do you opt out?
On the selection form the Department will issue, you will circle "opt out" so you are not automatically assigned to a health plan. You may also opt out by telephone.

6. If people choose to opt out are they off Medicaid?
No, there is no change. Those who opt out will remain in the Medicaid fee for service program.

7. If people choose to opt out is coverage identical the next year?
In the second year (Step 2), enrollment in the care management program will become mandatory. The Medicaid covered services requirements both in and out of the care management program will continue to be determined by what is in the State Plan and Rules.

8. What if someone chooses to opt out and then decides they want to be part of the care management program?
Individuals who choose to opt out initially are allowed to enroll in the program if they later change their minds.

9. What about those in Katie Beckett?
Katie Beckett is a Medicaid eligibility category. In Step 1, a child on Katie Beckett can opt out of the care management program and will still receive benefits in the fee for service program.

10. What about adults in nursing homes?
Nursing home services are part of Step 2. However, as part of Step 1, if a person in a nursing home were to be hospitalized for a surgery or needed behavioral health support that is not covered by the nursing home, then those services would be covered under the care management program.

11. What about Medicaid to Schools?
Medicaid to Schools is not included in care management.

12. If you have a Medicaid recipient under waiver services and Qualified Medicare Beneficiaries (QMB) what do they fall under?
Medicaid waiver services and QMB are part of Step 2, which is scheduled to start one year after Step 1. Individuals who receive both Medicaid and Medicare can opt out in Step 1.

13. Those who are on Supplemental Security Income (SSI) can opt out. Why would they want to opt out?
Some individuals may be concerned about the change to the new care management program and may initially opt out.

14. The Children's Health Insurance Program (CHIP) is becoming part of Medicaid. What are those children eligible for?
They are eligible for all of the Medicaid funded services and will be in the care management program. The CHIP program has transitioned to the full Medicaid benefit with no premiums or co-pays. Families will enroll their children in one of the three health plans. Dental benefits for children are also included in the full Medicaid benefit but are not part of the care management program.

15. Pregnant women are only eligible for Medicaid when they are pregnant, how does care management affect them?
Pregnant women will choose an MCO when they become eligible. The MCO will cover them on the first of the month after they become eligible. Until then they will be fee in the for service program.

16. How does Medicaid work for pregnant women who were on Medicaid Gold but aren't anymore?
The Medicaid eligibility requirements remain the same.

17. Why is the dual eligible population able to opt out?
The reason the dual eligible population is able to opt out is due to federal requirements.

18. Does "excluded" mean just excluded from Step 1?
No, it means a particular population is excluded from the care management program. These individuals will continue to use fee-for-service and experience no changes in their Medicaid services. These individuals are members with Veterans Administration benefits, Qualified Medicare Beneficiaries, (QMB), Special Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Working Individuals (QDWI) (with no Medicaid eligibility) and those on spend down. Some QMB, SLMB or QDWI individuals also have Medicaid, and are considered "dually eligible." They are allowed to opt out in Step 1.

19. Is it going to be easy to transition into the care management program?
The Department is working with the health plans to ensure that transitions for individuals are well coordinated.

20. Do you think those that are eligible to opt out should opt out?
There is no one size fits all answer to this question. The Department wants to make sure that individuals have the information they need to make a decision that is right for them.

21. What is the advantage of signing up in Step 1 for those who can opt out?
The advantage of enrolling with a health plan is better coordination of care and the benefit of being able to take advantage of the options that will be available through the health plans.

22. Is substance abuse treatment included in mental health benefits?
As part of Step 2, the health plans are required to cover a new substance abuse service provided by Master Level Drug Abuse Counselors.

23. In order to address the budget issue, will Medicaid eligibility be changed?
No. Eligibility requirements will not be changed. The current eligibility level cannot be reduced now due to federal law.

24. Is Special Low-Income Medicare Beneficiaries (SLMB) still part of Medicaid?
Individuals who have SLMB and no Medicaid eligibility are excluded from the care management program. Those with both SLMB and Medicaid can opt out in Step 1.

25. Which step is mental health?
Mental health services are included in Step 1.

26. Can I assume my son is required to be part of the care management program if I get an enrollment packet in the mail?
Yes. You will get a letter listing the enrollee's name that will request that you choose a health plan. If the individual is in one of the categories that allows for opting out, that information will be provided, too.

27. What about children's dental benefits?
Dental benefits are not included in the care management program and will continue to be provided as they are now. There is no adult dental benefit in NH Medicaid.

28. Is the Buy In program over in September?
The Buy In program was outside of the Medicaid and CHIP program and is scheduled to end on August 31, 2012.

29. If you have a child on Katie Beckett who turns 18 during this cycle what happens?
Before the child turns 18 you will need to switch his/her eligibility category to Aid to the Permanently and Totally Disabled (APTD). The sooner you can process an application for APTD, the better. Prior disability certification will make the process move more smoothly.

30. If a client is on MEAD and is changed to straight Medicaid, how will that affect their Medicaid? Will they be in the fee for service program? or switched to care management if the change to their Medicaid status takes place after January 1, 2013?
Being on MEAD means that the person would be in the care management program for their acute care services as a part of Step 1. If they switch to regular (non-MEAD) Medicaid after January 1, 2013, they will remain in the care management program.

31. If an adult with a developmental disability selects one of the health plans this year in Step 1, do they have to use the same company in Step 2 for long term care services?
There will be an open enrollment period every year at which time individuals will be able to change plans to meet their needs. If the person does not switch to a different health plan during the open enrollment period then they will use the same health plan for Step 2 long-term care services.

32. If a person has Medicare and MEAD (dually eligible) how will Care Management impact them?
Individuals who are dually eligible are optional in Step 1 and will be required to enroll in the program in Step 2.

33. Will enrollees need to have both a health plan card and a Medicaid card?
Yes. The Medicaid card serves as evidence of Medicaid eligibility while the health plan card indicates which health plan someone is enrolled in.

34. Why do they need to present both cards?
Not every single service will be in care management. Every member will have two cards because some services will be managed by the health plan and some will not. It depends on the specific service needed as to whether the state or the health plan will be billed.

35. How will payment be made for retroactive eligibility?
Those bills will be paid in the state's fee for service program, not by the health plan.

36. Will you guarantee the next level of care from one setting to another mid-month if someone's enrollment hasn't started?
Yes, but we would use fee for service until the care management program enrollment starts.

37. Why do you offer opt out for the first year?
It is a federal requirement for certain eligibility categories.

38. What does "children with special health care needs" mean?
It is a federal definition for children using special medical services.

39. Why are some people completely excluded from Care Management?
Those who are excluded either do not use Medicaid services or use so few Medicaid services that it makes more sense from an administrative and service delivery standpoint to be excluded.

40. What about the transition from a hospital to skilled nursing services?
Eligibility won't change. Skilled nursing services are part of Step 2.

Enrollment

41. Do you anticipate that the health plans will have their provider network in place by the time people need to enroll?
By contract, the health plans are required to have their provider networks in place prior to the enrollment period.

42. If Medicaid recipients do not like their plan, can they change it?
Yes, they have a window of 90 days to change plans after the initial enrollment. After that there will be an annual open enrollment period to change plans.

43. Will there be assistance for the elderly that need to enroll? What is the role of the guardian?
There will be an enrollment call center to assist all those who are eligible to enroll. A guardian also can help by giving information that will enable the individual to make an informed choice.

44. How can providers help low functioning, mentally disabled clients make the best decision for being enrolled?
Providers can help them by giving them information about the advantages and disadvantages of each health plan's networks. Providers should not, however, make the choice for these individuals unless authorized to do so by guardianship or power of attorney or with an authorized representative declaration.

45. Will the ServiceLink program help out?
Yes, the ServiceLinks will be available to assist individuals with health plan enrollment.

46. Can different family members sign up for different health plans?
Yes, but one plan for the whole family may be a good idea. If the concern is that one plan is better in one area than another, it is important to weigh the pros and cons of enrolling family members in different plans.

47. What is the deadline to pick a plan?
The deadline is 60 days after receiving the first enrollment packet, which will be mailed in late fall.

48. When the first open enrollment takes place after care management is in place, does everyone have to choose a health plan again or do they get automatically enrolled?
No, you do not have to change your health plan. If you are satisfied with your current one then you do not have to do anything and you will remain in the same plan.

49. Can those members that are eligible to opt out switch health plans?
Everyone who is in the care management program will have 90 days to switch plans initially, and thereafter during the annual open enrollment period.

50. What happens if a health plan has an individual who does not want to participate?
It is the obligation of the health plan to continue to work with an individual as much as possible. Disenrolling a member can only happen in limited situations. Before this could happen the Department of Health and Human Services (DHHS) would review the case.

51. What about someone who is new to Medicaid in January? How long do they get to choose a plan?
Everyone who is new to Medicaid will have 60 days to choose a plan.

52. Is DHHS going to notify the health plans about eligible Medicaid participants?
Medicaid recipients will get enrollment packets with all of the information needed to select a health plan. Once a recipient selects a plan, DHHS will notify the health plan chosen by that recipient.

53. If we need assistance with enrollment and choosing a plan, who do we contact?
DHHS will provide access to staff fully trained to assist with the enrollment process and decision-making.

54. What about those individuals who are under guardianship?
The letters from the Department would go to the guardian and the guardian would work with the individual to discuss the best option and choose a plan.

55. Does the date of my annual redetermination interact with my open enrollment?
No, open enrollment is the same for everyone each year.

56. Are these calendar or fiscal years?
The enrollment will have a unique date. It is not tied to a fiscal year.

57. Will authorized representatives of Medicaid beneficiaries be getting a letter?
If the authorized representative is authorized to receive the letter, they will receive it.

58. What happens if you accidentally don't sign up with a plan?
Individuals who do not sign up with a health plan will be automatically assigned to one. They will then have the option to switch plans within 90 days if they so choose.

Care Management

59. Who provides care management?
The three health plans, also known as Managed Care Organizations (MCOs), will have care managers that work with members who have chronic conditions. Not everybody will have a care manager. The health plans will determine who will be assigned a care manager.

60. Who is the care manager? What is the training of a care manager?
The care manager works for the health plan and has the responsibility to facilitate desired outcomes for certain members with chronic conditions. Each health plan has training requirements for staff. Care managers will be trained based on their requirements. Most care managers have nursing, therapy, or social work backgrounds.

61. I already do care coordination (for my family member). Will that change?
If you do care coordination for your family member, you will still have the same opportunity under care management. If the health plan assigns a care manager they will work with you and complement/enhance the coordination that you provide. The health plans will work with families to make sure that a coordination of care is optimized to the fullest.

62. Who gets to prescribe in a care management setting and who has the final say on what is medically necessary?
Physicians, specialists and other health care providers licensed to prescribe may do so. However, care management is all about professionals communicating with each other. The specialist and primary care physician will decide what to prescribe. According to the contract and federal law, the health plan must provide medically necessary services as required in the State Plan and rules. If a member disagrees with a health plan's decision, there is a process providing additional levels of review that includes further health plan review and, if necessary, access to the State's fair hearing process.

63. Will health plan care managers work with mental health case managers?
Yes, in order to ensure the best outcomes for the individual, discussions must take place between the health plan care managers and providers, including the mental health case managers.

64. What triggers the care manager to call a person?
Care managers are assigned a group of enrolled members, who they initially screen and who typically have chronic health conditions. The screening will tell them what services the patient has used, number of emergency room visits, etc. Once these trends are identified, the care manager will make contact with the individual/family and offer assistance to improve access and provision of care.

65. Can a family contact a care manager?
Yes. Families will be able to call care managers or meet with them in person, as some care managers will be placed around the state.

66. How much authority does the care manager have in making medical decisions?
Care managers are in the role of offering assistance. As such they will operate within the bounds of the Medicaid regulations and MCO policies. Moreover, they can't override a decision by an individual or family or force anybody to do anything.

67. We have frequent emergency room visits. Will the care manager help us with that?
Yes, those members who use ERs frequently are typically assigned care managers. With better linkages and with a health plan care coordinators' assistance, the need for frequent emergency room visits should lessen.

68. Hasn't it been proven that developmental services aren't successful under a care management model?
Providing developmental services in a care management model is a fairly new inclusion so there is not enough information to determine success or failure. Health plans and their care managers will be taking a whole person approach and will be expected to sustain the successful practices and outcomes of the current developmental services system in Step 2 of the care management program.

69. Is the health plan going to monitor how we are taking care of our families?
Care managers are not going to try to take away the role that you play in your family members' care or care coordination. Care managers will work with you and support you.

70. What about confidentiality concerns?
All federal and state confidentiality requirements apply to the health plans and providers.

71. What happens if a parent chooses not to follow through with a recommendation of the care manager?
The organization will continue to work with the parent to do what is in the best interest of the child.

72. Is the care plan written as a team or is it generic?
The person-centered approach used by care managers and MCOs would mean that both the planning and provision of services would be based on an individual's specific needs. The individual's unique situation and personal health care goals will determine the features of the plan.

73. How does the care manager understand what is going on?
All of the providers will be a part of that health network and will document information about the members. The health plans' Information Technology systems will provide access for care managers to connect to providers and receive information about the members and their needs.

74. Who determines who gets a care manager?
This will be done in conjunction with the individual, the health plan and the primary care provider. Typically a care manager is assigned when the individual has a chronic condition.

75. What's the difference between care management and case management?
A health plan care manager will have access to the health care data for the individual. If the health information shows that the individual has serious medical needs, the care manager will focus on that person to see if their care is coordinated. If that person has case management for supported employment

(for example) then the care manager will with work with the case manager to insure that the person's health care needs are addressed so that they will not miss time from work.

76. Will health plan care management be modeled after case management?
They are two different functions. Case Management is an overarching service that is offered by human service agencies to a number of Medicaid recipients who receive services and supports through those agencies. Care Management is typically intended for those with chronic health conditions.

77. What's the ratio between care managers and consumers?
The ratios are going to depend on the number and the health care needs of the individuals who sign up for the health plans. Rather than dictate ratios we have required outcomes for care management that will then drive the staffing ratio.

78. So some people will have a care manager and a case manager?
Yes, some will. The care manager will supplement the case manager in some cases.

79. Do care managers do home visits?
In some instances they do, depending on the needs and circumstances of the individual and family.

80. Is care management going to solve the problem with the difficulties families have in getting appropriate equipment such as wheel chairs?
A care manager will help support the caregiver with a variety of needs, including facilitating the accessing of equipment.

81. What if I'm already engaged in a course of treatment when we switch over to the care management program?
The health plans must honor prior authorizations in the first 90 days and continue the treatment. After 90 days the plans have the opportunity to reevaluate and reauthorize treatment.

82. What happens if your treatment isn't reauthorized within 90 day when your time to change a health plan is up?
You can appeal that decision to the health plan. If you are not satisfied with the result of your appeal, you then can go through the appeals process at DHHS.

Choosing a Plan

83. If someone does not choose a health plan what is the default?
Those who don't make a choice will be automatically assigned to a health plan. We will look at claims history for the person and then look to see what network their current provider is located in. A letter will go out 15 days prior to the auto assignment date to remind people of their ability to choose among the three plans. If they don't they will be automatically assigned to a plan.

84. How will we know which plan our current providers are in?
DHHS will have a list of all providers that are in each network with the health plans, and the information will be on our website.

85. What will happen if someone's providers are in different health plan networks?
There will be some overlap between networks, as providers are able to sign up with all three health plans. There is no prohibition as to which health plan a provider may join. Ultimately, individuals will need to

choose a plan to enroll in based on their determination of which plan offers the best access to the providers they need.

86. Will the health plans have to describe their processes?
Yes, this is in their contracts. The health plans provide information to their members about their plans, describing the services they offer and processes they follow.

87. Is the Department going to help people choose a plan?
Yes, if people want assistance. The Department will also provide comparison information on the three health plans in the enrollment packet.

88. Can primary care providers handle the volume?
The health plans' contracts require that they have enough primary care providers and specialists to serve their members.

89. Are providers enrolling in health plans now?
The health plans are in the process of developing their provider networks. Providers are encouraged to reach out to the three health plans if they have not been contacted yet by the plans.

90. Which of the health plans have experience in home and community based services?
Some of the plans have experience with Choices For Independence (CFI)-type waivers; some have experience with children and the elderly. The key is that the work the health plans have done has been successful.

91. Is there outcome data information (quality data) for the health plans?
Outcome data information will be available in the future on a DHHS website. This will not be part of the enrollment packet that you will receive in October.

92. What is the turnaround time for grievances?
The health plans are expected to complete the disposition of a grievance and provide notice to the affected parties as expeditiously as the member's health condition requires, but not later than forty-five days from the day the plan receives the grievance.

93. Will the health plans have local presence?
Yes. All three health plans have offices and staff located in New Hampshire.

94. Are the health plans' call centers located in New Hampshire?
The call centers are available statewide, but not necessarily physically located in New Hampshire.

95. Is a single doctor likely to be in more than one health plan?
Providers are able to sign up with all three health plans, but it is possible that a particular doctor or specialist would be part of one health plan and not the others.

96. What happens if there isn't a hospital and or other physicians in a region in one of the health plans?
The state will be conducting reviews to make sure all of the health plan networks are complete, so that everyone has local access to the healthcare they need.

97. Are there any rules for what is an adequate health plan network other than from DHHS?
The Medicaid care management contracts contain provisions for network adequacy based on NH Insurance Department requirements. In addition, there are federal requirements.

98. What recourse does an individual have if requirements for care are not met?
The health plans are held accountable by the state to continue to provide, at a minimum, the level of covered services required in the State Plan and Rules. There is also a quality component as part of the contracts with the health plans. If you feel that your health care is not as good as it was or is not what you want, you have the right to file a grievance and/or appeal with the health plan.

99. Are the health plans non-profit?
One is non-profit and two are for-profit.

100. Are there going to be enough primary care providers?
The health plans aren't going to bring new primary care providers to the state. It is the responsibility of the health plan to have enough primary care providers in their networks to serve plan enrollees. It is a contract requirement.

101. Will all three plans work with all ten community mental health centers?
They can, but there is no requirement as long as the plan establishes an adequate network of services.

102. What defines an adequate network?
Basically it means that a health plan needs to be able to ensure access in travel distance and for timely appointments for the number of individuals it enrolls.

103. Will there be a way to see if your providers are enrolled in each health plan?
The health plans websites will have that information and the Department will have a telephone number to help with enrollment that also will have that information.

104. Will managed care organizations rely on utilization data or will they be doing health risk assessments on clients?
They will use both.

105. When will the medical homes be operational within the health plans?
Everyone will have a primary care provider. The health plans may choose to use a medical home model.

106. People are concerned about the integrity of the health plans and the quality of their services.
The health plans are held accountable by the state to provide, at a minimum, the level of covered services required in the State Plan and Rules. There is also a quality component as part of the contracts with the health plans.

Covered Services

107. Are the health plans going to have pharmacy lists?
The health plans formularies must include the NH Medicaid Preferred Drug list as developed by DHHS. Formularies also must comply with federal requirements and are subject to DHHS approval.

108. Will each plan have prior authorizations? And how will they coordinate with state rules?
Yes, they will have prior authorizations. However, the health plans must provide medically necessary services as currently defined in the Medicaid State Plan and Rules.

109. Is the four emergency room visits rule still in play?
Health plans are not required to limit services and may be more lenient than the current fee-for-service program. However, they must provide emergency medical services when a person's health or physical condition is life threatening and requires emergency treatment. The state rule limiting the number of emergency room visits to four will continue to apply to fee for service and may also be imposed by the MCOs.

110. When will the adult dental aspect of the Medicaid benefit be fixed?
There have been several oral health legislative committees on this issue and everyone thinks that it is important. DHHS proposed the inclusion of an adult dental benefit in the state Medicaid program, but it has not been funded by the legislature.

111. Are you going to tell us how many visits we will be allowed to have with care managers?
The contract requires that the MCOs develop a strategy for coordinating all care for all members. Care coordination for its members includes coordination of primary care, specialty care, and all other MCO covered services as well as services provided through the fee for service program.

112. Will there be different systems for pharmacy?
The health plans will have data on the use of services, including pharmacy. The plans will assist in the coordination and monitoring of medications.

113. Who is paying for prescriptions?
The pharmacy benefit is part of the care management program and will be administered by the health plans.

114. How is transportation to and from the North Country going to work?
The contracts establish accessibility standards. Accommodations will be made through the health plans.

115. What is the timeline for authorizations for a private duty nursing visit?
In most circumstances, the health plans are required to make determinations for authorizations no more than 15 calendar days after receipt of the request.

116. What will happen if you disagree with the recommendations from your doctor?
There are stipulations in the contract that allow for second opinions. Appeal rights also are included in the contracts.

117. Under this program if the health plan pays a bill presented by the provider is the provider obligated to accept the payment?
The health plan and provider should have a contract in place that spells out the terms and conditions of payment. The provider will know this before requesting a payment. Medicaid members cannot be billed for services or for the difference between what the provider charged and the health plan paid. Plan payment is considered payment in full.

118. Many Medicaid members do not have primary care providers. Will that delay services to them?
The health plans will work with each member to ensure that they have a primary care provider so that services are not delayed. Also, there are very specific contract requirements for how long individuals can wait for an appointment.

119. Can a primary care provider say that I cannot go to a specialist?
Yes, it is possible. However, arrangements to see a specialist can usually be made.

Out of State Specialists

120. Will recipients be able to use out of state doctors?
Possibly. Out of state doctors need to agree to be part of the health plan's New Hampshire network.

121. What happens with out of state emergencies?
In medical emergencies, individuals will go to the closest hospital to be treated.

122. Specialty care in Boston: will the health plans have providers representing the Boston community?
The health plans are required to demonstrate that they have the providers needed to serve their New Hampshire members' health care needs. In fulfilling that requirement the health plans may contract with out-of-state providers (including the ones in Boston) to create an adequate network of providers.

Coordination With Other Insurance

123. Can you list Medicaid as your primary insurance?
If you have private insurance and Medicaid, your private insurance is primary and Medicaid is secondary.

124. Will we lose access to our private insurance?
No, private insurance is the first form of funding for services. Medicaid or care management will not adversely impact accessing your private insurance.

125. What is the communication going to be like between Medicaid and Medicare?
Care management is focusing solely on the state Medicaid program.

126. Does this care management program affect Medicare Part D?
Care management does not affect Medicare Part D.

127. How can you have private insurance, Medicare and Medicaid?
Having other insurance does not disqualify people from using Medicaid if they are eligible for it.

Public Information/Communications Logistics

128. What if I don't have access to the Internet?
Care managers will work to help Medicaid members without Internet access. The NH DHHS Medicaid Client Services Unit also will take questions by phone and the health plans will have call centers.

129. Who do case managers contact to help consumers if they don't receive, or they lose, the enrollment information letter?
Assistance will be provided by the Department through an enrollment call center.

130. Who will the letters go to? All current Medicaid recipients?
Yes, the first letter is general and goes to everyone. The second letter will be more specific to the type of eligibility of the individual. [Note: Those who are excluded from the Care Management program will not get the second letter and do not need to do anything. They will continue to receive services in the fee for service program.]

131. Will the letters be translated into different languages?
The first letter will have one side English and one side Spanish.

132. Will the letters and information be available on a website?
Yes, the letters and information will be on a DHHS website. Right now, information can be found at **http://www.dhhs.nh.gov/ocom/care-management.htm**.

133. When will we get information about opting out?
The second letter will tell you how to opt out. Opting out also can be done over the phone or online.

134. Will there be a way for consumers to comment on the organization they have chosen in a way that could be open to the public?
Yes. There will be a client satisfaction survey conducted using the Consumer Assessment of Healthcare Provider's System (CAHPS) survey tool. We will have the opportunity to compare the current baseline to the new program.

135. Are the Medicaid rules on the website?
The Medicaid rules are on the web at: **http://www.gencourt.state.nh.us/rules/state_agencies/he-w500.html**

136. Is the NH Easy website 504 compliant?
The NH Medicaid Care Management website will be compliant with the Federal Department of Justice Accessibility of State and Local Government Websites to People with Disabilities standards.

137. If the Department is online and on Facebook and Twitter, why am I still filling out paperwork in long hand?
We are trying to convert to the web but we want to have all options available: paper, phone, and web.

138. Will there be provider sessions scheduled?
We are currently in the process of developing our outreach to providers. Information will be posted on the Care Management website.

139. What can we do if we don't get a letter? What can we do to get the information we need?
We know that some letters may get returned due to incorrect addresses. We plan to reach out to every person whose letter is returned to us. We will also offer a toll-free number to answer any enrollment questions you have. If you do not get a letter and are concerned about that, you can call the toll free number that is being set up.

140. Where can people find information if they need help?
There will be an enrollment telephone number people can call for more information. We are planning provider training sessions, too. The new Care Management website also will have information to help you.

141. Will there be other meetings to provide more information to consumers -- other than by phone?
Yes, we anticipate additional meetings for consumers and providers.

State Oversight and Funding

142. Why are there three health plans?
There are three health plans because the federal government requires at least two in order to give consumers a choice.

143. What will DHHS still have control over?
DHHS remains responsible for ensuring the provision of services for Medicaid members. It is responsible for overseeing and enforcing the health plan contracts.

144. Will each health plan have its own reimbursement rates?
DHHS pays the health plans one rate that is inclusive of various services. The health plans will have agreements with providers that will spell out the payment arrangement between the two parties.

145. What oversight will DHHS have with the health plans?
The Department will provide oversight of the health plan contracts. All of the requirements will be overseen by experts within the Department. These include, but are not limited to, the areas of quality, data reporting, member services and network management.

146. Will these health plan contracts take away from services that are needed in other areas?
The health plans will assist with the coordination of services to improve the quality of care and lower costs.

147. How can the health plans' contracts vary?
There are certain requirements that all the health plans must meet, for example, network adequacy, patient and provider services, call centers, etc. One area that can be different is the payments between the health plans and providers. Another is that one health plan may offer a special program that another may not. For example, one may have a special program focused on obesity while another may offer smoking cessation.

148. Are the contracts for one year?
The contracts with MCOs initially are for three years with one two-year option for renewal.

149. What impact will this have on the InShape program?
The InShape program will continue. We partnered with Dartmouth College and received a 5-year grant and the intent of the grant is to expand the InShape program statewide.

150. Will there be any changes in the children's dental reimbursement rate?
Children's dental benefits are not part of the care management program. The rates remain the same for the state fiscal year.

151. Does the state have plans for an appeals process?
Yes, there will be three opportunities. You can file a grievance or an appeal. If you go through the appeal process with a plan and you aren't successful, you can appeal to the state.

Step 2

152. When does Step 2 begin?
Step 2 is scheduled to start one year after the start of Step 1.

153 When will the Step 2 design process take place?
This process will start in the fall of 2012.

154. How can I participate in the design of Step 2?
Please send an email to us at nhmedicaidcaremanagement.dhhs.state.nh.us or look on our website for updates on the Step 2 design process.

155. Would short-term rehabilitation be reimbursed under care management?
Skilled nursing and home community based waivers are in Step 2.

156. Are current Area Agency Case Managers secure for next year?
Step 1 is about medical care; most case managers are with Area Agencies or Community Mental Health Centers. Current agency case managers will be working with the health plans' care managers to help individuals. Care managers from the health plans will not be replacing the case managers from area agencies or mental health centers. Health plan care managers will complement the work of the agency case managers**.** There is more to discuss about this as Step 2 is developed. The health plans are required to include mental health providers in their networks in Step 1.

- end-

Medicaid Care Management Program
Guiding Principles

1. All services will be person/family centered based on an informed-choice, consumer-driven model.

2. Services will be designed to achieve intended outcomes within the context of available financial and human resources.

3. Clients and their caregivers will be educated and informed about their options.

4. The value of services will be measured by health outcomes achieved per dollar spent (cost).

5. All participants within the system, including program administrators, providers, families and clients, will be held accountable to achieve a high level of care through transparent process of continuous evaluation of quality and cost.

6. All participants within the system will be compliant with state and federal laws, regulations and contracts.

7. Culturally competent care will be integrated and coordinated across all systems to achieve the intended physical, behavioral and human service outcomes of all populations.

8. Services will be provided in a fair, equitable and reasonable manner using evidence-based approaches.

9. Stakeholders will be engaged in the design, development and implementation of the system of care.

10. The care management system will be responsible for measuring the impact of services on the Medicaid population as a whole and will continue to improve services to achieve better population health.

— New Hampshire Department of Health and Human Services